elect to purchase the wheelchair. If the beneficiary elects the purchase option, Medicare will make 3 additional monthly rental payments, and then the beneficiary owns the wheelchair. If the beneficiary declines this purchase option, Medicare will make 5 additional monthly rental payments, and the supplier, not the beneficiary, owns the wheelchair.

POVs

Beneficiaries may choose to rent or purchase a POV/scooter. If the rental option is selected, the supplier retains ownership of the POV, and Medicare limits its total rental payments to the purchase price. Therefore, if the beneficiary needs the POV for an extended period, purchase is a preferable option.

NOTE: If the power wheelchair is rented, Medicare will pay 80% of the allowable service and maintenance charge once every 6 months, whether or not the equipment is actually serviced, to the extent that the charges are not covered under a supplier or manufacturer warranty. Therefore, the beneficiary must pay 20% of the allowed service charge as his or her co-insurance once every 6 months.

If the power wheelchair or POV is purchased, Medicare will pay 80% of the allowable service and maintenance charge each time the equipment is actually serviced.

FOR MORE INFORMATION ABOUT PMDS, DME, OR MEDICARE, PLEASE VISIT ONE OF THE FOLLOWING ONLINE REFERENCES:

Medicare Learning Network (MLN)

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at *www.cms.hhs.gov/MLNGenInfo* on the CMS website.

Medicare Coverage ~ Mobility Assistive Equipment Web Page

www.cms.hhs.gov/CoverageGenInfo/06_wheelchair.asp
This web page contains links to numerous policy and Q&A documents related to MAE and PMD policy.

Medicare Coverage Database

www.cms.hhs.gov/mcd/search.asp?
The Medicare coverage database permits searching of National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and DMERC provider education articles regarding coverage policies.

Medicare Claims Processing Manual

www.cms.hhs.gov/Manuals/IOM/list.asp
The Medicare Claims Processing Manual describes the basic billing requirements. Chapter 20 focuses on DME billing.

Medicare Learning Network

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DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Centers for Medicare & Medicaid Services

Changes in Medicare Coverage of Power Mobility Devices (PMDs): Power Wheelchairs and Power Operated Vehicles (POVs)

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Learning Network

Medicare conditions of coverage have changed to conform to the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. Under the new coverage policy, effective October 25, 2005, power wheelchairs and Power Operated Vehicles (POVs or scooters) are collectively classified as Power Mobility Devices (PMDs). PMDs are covered under the Medicare Part B benefit.

Durable Medical Equipment Regional Carriers (DMERCs)[1] process Medicare claims for PMDs furnished by suppliers. According to the new guidelines, to qualify for Medicare reimbursement, the physician or treating practitioner must do the following:

- Conduct a face-to-face examination of the beneficiary.
- Write a prescription for the PMD within 30 days of the examination (45 days after the examination beginning June 5, 2006).
- Furnish pertinent beneficiary medical information to the supplier to support medical necessity.

A completed Certificate of Medical Necessity (CMN) is no longer required for claims with dates of service on or after May 5, 2005. However, until Medicare's systems are fully updated, DME suppliers will need to continue to submit a partially completed CMN with all claims (only sections A and C need to be completed). The Centers for Medicare & Medicaid Services (CMS) expects to update their systems by spring 2006. Physicians, treating practitioners, and suppliers should contact their Medicare contractor/MAC for current requirements.

Effective May 5, 2005, CMS revised national coverage policy to create a new class of DME identified as Mobility Assistive Equipment (MAE), which includes a continuum of technology from canes to power wheelchairs. CMS has determined that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair the performance of Mobility-Related Activities of Daily Living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. The newly developed Clinical Criteria for MAE Coverage must be used to determine the appropriate MAE for each individual, replacing the previously used "bed- or chair-confined" criterion.

MEDICARE COVERAGE PROVISIONS

A PMD is a covered item of Durable Medical Equipment (DME) in a class of wheelchairs that includes a power wheelchair or a POV that a beneficiary uses in the home. Under the new MAE national coverage policy, PMDs may be medically necessary for beneficiaries who cannot effectively perform MRADLs in the home using a cane, walker, or manually operated wheelchair. The beneficiary must also demonstrate the ability to safely and effectively operate the PMD in the home environment. Although a PMD may be used outside the home, the beneficiary must first demonstrate a medical need to use it inside the home in order to be covered.

Requirements for Physicians and Treating Practitioners

Medicare no longer limits the type of physician that can order a PMD for a beneficiary. In addition, a physician assistant, nurse practitioner, or clinical nurse specialist may order a PMD. The physician or treating practitioner must be familiar with the provisions of the MAE National Coverage Determination (NCD) to discuss available options with the beneficiary and to identify the appropriate medically necessary PMD.

The physician or treating practitioner must conduct a face-to-face examination of the beneficiary before writing a PMD prescription. The following exceptions apply:

- A beneficiary discharged from a hospital does not require a separate face-to-face examination if the physician or treating practitioner that performed the face-to-face examination during the hospital stay issues the prescription and supporting documentation to the supplier within 30 days after the date of discharge (45 days after the date of discharge beginning June 5, 2006).
- The face-to-face examination is not required when only accessories for PMDs are being ordered.

In addition to the prescription for the PMD, the physician or treating practitioner must provide the supplier with supporting documentation consisting of pertinent parts of the medical record that clearly support the medical necessity for the PMD in the beneficiary's home. In most cases, the information recorded at the face-to-face examination will be sufficient to support medical necessity; however, prior documentation may be necessary when the information recorded at the face-to-face examination refers to pervious notes in the medical record.

Requirements for Suppliers

The supplier must obtain the prescription and supporting documentation prior to dispensing the PMD. Upon request, suppliers must submit to the Centers for Medicare & Medicaid Services (CMS) or its agents the PMD prescription and supporting documentation received from the physician or treating practitioner.

Also upon request, suppliers must submit additional documentation to support medical necessity, which may include physician office records, hospital records, nursing home records, home health agency records, records from other health professionals, and test reports.

NOTE: Physicians, treating practitioners, and suppliers should contact the DMERC for coverage instructions related to specific items. While the basic coverage criteria for power wheelchairs and POVs has changed, other coverage provisions for specific items (e.g., accessories) as described in Local Coverage Determination (LCD) policies remain in effect. DMERCs expect to update all LCDs related to MAE by early 2006.

CLINICAL CRITERIA FOR MAE COVERAGE

The new *Clinical Criteria for MAE Coverage* is a nine-question algorithmic process that replaces the "bed- or chair-confined" criterion historically used to determine if a wheelchair is reasonable and necessary. Before a beneficiary can qualify for a power wheelchair or POV, the Clinical Criteria for MAE Coverage algorithm must be sequentially followed by the physician or treating practitioner to determine which MAE is appropriate to meet the beneficiary's MRADL needs.

The Clinical Criteria for MAE Coverage may be viewed in detail (including a diagram) in Chapter 1, Part 4, Section 280.3 of the Medicare National Coverage Determinations Manual available at *www.cms.hhs.gov/manuals/IOM/list.asp* on the CMS website.

SUMMARY OF BENEFICIARY COSTS

If the beneficiary...	Then Medicare Part B will pay...	And the beneficiary will pay...*
Chooses to purchase the power wheelchair or POV...	80% of the allowed purchase price in 1 lump sum payment.	20% of the allowed purchase price.
Chooses to rent the power wheelchair...	80% of the allowed rental price for months 1 - 10.	20% of the allowed rental charge.
Chooses purchase option for the power wheelchair after 10 rental months...	80% of the allowed rental price for months 11 - 13.	20% of the allowed rental charge.
Chooses rental option for the power wheelchair after 10 rental months...	80% of the allowed rental price for months 11 - 15.	20% of the allowed rental charge.
Chooses to rent the POV...	80% of the allowed rental price. Total Medicare payments cannot exceed 80% of the allowed purchase price.	20% of the allowed rental charge.

* Beneficiary payment responsibility is based upon receiving equipment from a provider that accepts assignment. Beneficiary costs are higher when obtaining wheelchairs from suppliers that do not accept assignment. If the beneficiary is enrolled in a Medicare Managed Care Plan, the beneficiary will need to contact the plan to determine his or her costs. In addition, the managed care plan may require preauthorization and have a limited number of participating DME suppliers.

BENEFICIARY COSTS FOR PMDs

Power Wheelchairs

Beneficiaries may elect to purchase a power wheelchair when it is furnished. If the beneficiary declines the purchase option, Medicare will pay on a rental basis for 10 months. After the 10th rental payment, the beneficiary may again

[1] *Medicare Contracting Reform (MCR) Update - Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) enacted numerous contracting reforms. A key aspect of these reforms is that Medicare will begin integrating Fiscal Intermediaries (FIs) and Carriers into a new single authority, called a Medicare Administrative Contractor (MAC). As of October 1, 2005, new Medicare Contractors are called MACs. Also, from October 2004 through October 2011, all existing FI and Carrier contracts will be transitioned into MAC contracts, using competitive procedures. Providers may access the most current MCR information to determine the impact of these changes at www.cms.hhs.gov/MedicareContractingReform/ on the CMS website.*